WEST VIRGINIA I/DD WAIVER
TRANSFER/DISCHARGE

Must be received by the UMC **within seven calendar (7) days** of the transfer/discharge. Fax to (866) 521-6882 or email to wviddwaiver@apshealthcare.com.

Name of Person Who Receives Services		**Date**	
SC Agency		**APSID #**	

Transfer: From one Service Coordination agency to another.
An overlap of Service Coordination (up to 30-days) may occur for active participants.

Transfer From (Agency)		**Final Access Date** (last date of service provision for Transfer From agency-n/a if on the Wait List)	
Transfer To (Agency)		**Effective Date of Transfer**	

Reason For Transfer (✓)	☐	Participant requests new SC provider
	☐	Participant moved to a new geographic location
	☐	Provider no longer offers Service Coordination
	☐	Provider initiated transfer

Additional comments:

Discharge: Permanently exiting the program

Effective Date of Discharge		**Final Access Date** (last date of service provision-n/a if on the Wait List)	

Please check **(✓)** if discharge refers to: ☐ Active Participant ☐ Participant on Wait List

Reason for Discharge (✓)	☐	No longer a WV resident
	☐	Deceased
	☐	No longer eligible for I/DD Waiver
	☐	Voluntarily declines the I/DD Waiver program
	☐	Has not accessed direct support services in 180 days
	☐	Decided to receive support through an ICF/IID

Additional Comments:

Signature of Person Completing this Form		**Date**	
Signature of Person Who Receives Services		**Date**	
Legal Representative Signature		**Date**	
Witness Signature		**Date**	